MEDICAID SERVICE GUIDELINES

Revised Edition

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Division of Mental Health
Developmental Disabilities and Substance Abuse Services

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GUIDELINES FOR MEDICAID SERVICES

Area program staff engage in a variety of activities, some of which will be billable to Medicaid depending upon the service definition. Since all activities will not be reimbursed by Medicaid, they are coded and reported to the Division to "draw down" the area program's share of funding from other sources (e.g. MH/DD/SA unit cost reimbursement (UCR), *Thomas S.*, *Willie M.*, Special Categorical Funds). This document seeks to clarify which activities are to be coded for Medicaid reimbursement and the necessary documentation requirements for an effective audit trail.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) Medicaid audit is a quantitative and qualitative review of medical record documentation based on a random sample of Medicaid paid claims. Audit results are shared with the Division of Medical Assistance. The purpose of the audits is to ensure that MH/DD/SA services are provided to Medicaid recipients in accordance with Federal and state regulations and to ensure the accuracy and integrity of documentation and billing practices of area programs and contract agencies. Out-of-compliance issues are subject to payback. The Division provides technical assistance to area programs to assist them in ameliorating documentation and billing errors.

NOTE: The Division will be revisiting all Medicaid service definitions over the next year. As the service guidelines are revised, new insert sheets will be available to reflect changes as they occur.

Medicaid services, like all area program activities, must comply with specific standards. For Medicaid services, the following basic steps must occur:

I. Credential and Privilege Staff

In conjunction with the Division's quality improvement process, each area program and its contract providers are required to have a quantitative and qualitative process for credentialing and privileging staff providing services to consumers. Credentialing is the process by which a person's diplomas, academic degrees and educational experiences, professional licenses and certifications, and other qualifications, etc. are verified. Privileging relates to the Area Program's authorization of staff to perform specific treatment/habilitation activities.

The Division's *Rules for MH/DD/SA Facilities and Services* (APSM 30-1, 5/1/96, p. 5) set the **minimum standard** for the determination of a Qualified Professional. Each area program must then determine what specific clinical privileges will be granted or services each staff may provide. With the addition of staff who provide Client Behavior Intervention (CBI) services, the area program must also distinguish between professional and paraprofessional staff, with the primary difference being the assignment of primary case responsibility. Credentialing and privileging are both a quantitative and qualitative process.

II. Develop Individualized Clinical Supervision Plans

For staff who are **not** designated as Qualified Professionals, a plan for supervision of service delivery must be developed until such status is met. These plans should vary among staff based upon individual strengths and weaknesses. While a portion of clinical supervision may be in a group forum it is expected that a majority of clinical supervision will be done on an individual basis. The Qualified Professional who implements this plan has discretion in what specific skills or activities are needed in order to achieve the status of a Qualified Professional.

III. Open an Area Program Record

Pending records may be used while determining if the person will become an area program consumer. Medicaid may be billed for Case Consultation and Screening services during this period. Screening services are limited to two (2) within a 60-day period. Once a consumer is admitted to a service, a full record must be opened and include the following paperwork: Form B, Admission Assessment, Level of Eligibility, Confidentiality and other consents, documentation that Client Rights have been explained, emergency medical care forms, etc.

IV. Order the Service

Each Medicaid service must be ordered by the appropriate professional. The service order must indicate the date the service was ordered and include an authorizing signature. It is recommended that standing orders be adopted for Case Consultation, Screening and Evaluation services. All other service orders are to be based upon an assessment of the consumer's needs. Area

programs need to identify basic criteria to assure medical necessity for ordering services which may be referenced on the intake form, admission assessment, the levels of care criteria, other measures of functional assessment, or in policy. A Service Order must be in place *prior to* or on the day that the service was initially provided in order for Medicaid to be billed for the service. Service Orders are required only once per service.

V. Develop the Service Plan

In order for a service to be billed to Medicaid, a service plan must be in place. A service plan must be completed at the time the consumer is admitted to a service. A pertinent goal and service must be identified on the plan. The service plan must be updated to reflect new goals as new problems (needs) are identified and addressed.

Depending on the requirements for a specific population, you will use one of the following service plan formats:

- Standardized Service Plan
- Treatment Habilitation Plan (THP) – *Willie M.*, CAP-MR/DD
- Individual Family Service Plan (IFSP) – Early Intervention
- Essential Lifestyle Plan (ELP) – *Thomas S.*

Required elements for service plans can be found in the *Service Records Manual* (APSM 45-2, 9/1/98, p. 10) which apply for all records, including those developed for Medicaid recipients. The required components of *all* service plans include the following elements:

Identification of the Consumer's Strengths and Needs – This process begins at the time of first contact and is ongoing. Documents which reflect consumer strengths and needs include admission assessments, applicable measures of functional assessment (e.g. CAFAS, NCFAS, GAF, DD Screening/NC SNAP, AUDIT, DAST-10, ASAM Criteria, etc.), levels of care criteria, evaluations, intake/screening forms, person-centered plans, etc. The identified needs will determine the goals to be developed. The consumer's strengths should be reflected in the strategies implemented.

Diagnosis – Diagnoses are established either by a new assessment or by utilizing other approved sources for this information as appropriate (e.g. hospital discharge summaries, evaluations from outside agencies). A diagnostic impression is typically given at intake and/or possibly an

established diagnosis is given at intake and as the service plan is revisited. The diagnosis is one source for identifying strengths and weaknesses (signs and symptoms) to be addressed and should be present on the service plan.

Develop Goals – Goals are typically written about the consumer's need for change in a specific manner. Goals should be time-specific with target dates and should focus on what the consumer will do to address or improve his/her condition or presenting problem(s). Goals should be individualized and measurable. Typically, the broad goal will be the same for homogenous populations (e.g., *Willie M.* consumers need to reduce aggression; adults with bipolar disorder will need to comply with medication); however, the measure of progress will offer individualization (example: reduction of aggression for one consumer will be fights at school whereas for another consumer will be the verbal abuse of spouse). **One service plan can be adequate for multiple services (e.g., an integrated service plan) as long as the individual staff interventions are enumerated as they are added.** Following is an example of this process:

A consumer began outpatient treatment with one goal of the service plan being to reduce angry outbursts as evidenced by only one verbal fight with family members per month. The interventions used by the therapist were individual therapy 2x month and an anger management group 1x month to address verbalized concerns about verbal and physical aggression and to employ and model stress management techniques. These interventions were ineffective, and the therapist referred the consumer for CBI services within three months. The CBI supervisor reviewed the record and added an addendum to the admission assessment indicating that relatives had recently moved to the community resulting in additional family stress and conflict. The same service plan was used with the addition of CBI as a staff intervention with supportive counseling, modeling, and de-escalation techniques to be employed.

Service Intervention with Frequency – Interventions are those activities identified in the service plan to facilitate consistent implementation. The frequency of the service (i.e., how often the service will be provided) should be included in the service plan. The staff interventions will be reflected in the progress notes and should incorporate the consumer's strengths and preferences as much as possible. When writing integrated service plans, the various services to be provided and the interventions employed will need to be enumerated to the degree that they could "stand alone" as a separate plan. At the same time, they must be

general enough to prevent constant updating as the consumer's situation changes (example: monitor supported living services vs. monitor residence in Taylor Apartments).

Responsible Person – The identified position or person who's responsible for each service.

Consumer Participation in Development of the Service Plan – Area Programs are required to demonstrate involvement of the consumer and, if applicable, the legally responsible person's participation in developing the service plan. Consumer participation in the development of the service plan and consent of agreement with the plan is evidenced by the consumer's signature on the signature page of the plan. If a signature cannot be obtained from the consumer and/or legally responsible person, the reason why the signature could not be obtained must be so noted by a written statement in the service record.

VI. Documentation Requirements for Service Provision and Billing

Staff completing event tickets/contact sheets are responsible for accurately documenting services to be reported to Medicaid. For periodic and day/night services, this means a heightened awareness of the time engaged in each activity, whether it complies with Medicaid reimbursable guidelines and its relationship to the service goals. Actual service time is totaled at the end of the day by the provider and rounded up to the nearest 15 minute interval by the Area Program's MIS. For 24 hour services, the bed count (census) at midnight constitutes one (1) billable unit of service for each consumer present in the program.

Per the *Service Records Manual* (APSM-45-2, 9/1/98, p.16), service notes need to include the purpose of the contact, a description of the activity or intervention and the effectiveness of the intervention. More simply put, a description of why the contact is taking place, a description of the staff person's intervention and the effectiveness (outcome) of this intervention are the required elements of the service note. Various formats can be adopted to help staff include all elements such as PIE, SOAP, BIRP, GIO, etc. *Progress notes are **not** a narrative of all consumer-staff activities, but rather a synopsis of staff's interventions and the consumer's response to those interventions.* The frequency and format for documentation vary according to the service provided. Following is an outline of documentation requirements:

MEDICAID SERVICES
DOCUMENTATION REQUIREMENTS

SERVICE	FREQUENCY	FORMAT
Case Consultation	Each event	Per Area Program Policy
Screening	Each event	Per Area Program Policy
Evaluation	Each event	Report, Service Note, or Assessment Form
Outpatient Treatment (Individual or Group)	Each event	Service Note
Case Management	Each event	Service Note
High Risk Intervention-Periodic (Individual or Group)	Each event	Service Note
HRI-Individual/Group for ECI children or children under 7 in Developmental Day settings	Each event	Contact Log
Client Behavior Intervention-Individual	Each event	Contact Log
Client Behavior Intervention-Group	Each event	Contact Log or Service Note
Assertive Community Treatment Team	Each event	Contact Log
Day Treatment/Partial Hospitalization	Weekly	Service Note
Psychosocial Rehabilitation	Monthly	Service Note
Professional Treatment Services in Facility-Based Crisis Programs	Each Shift	Service Note
Residential Treatment:		
Family Type	Daily	Contact Log
Family/Program Type	Daily	Contact Log
Residential – High	Each Shift	Service Note
Residential – Secure	Each Shift	Service Note

- In order for an event to be billable, the service note or contact log entry *must relate to goals listed in the service plan.*
- A service note should address the *purpose* of the contact, the *staff intervention* (what the staff did) and the *effectiveness/outcome of the intervention* (the consumer's response to the intervention).
- Contact log entries must include the *staff intervention.*
- Residential Treatment-Family Type and Residential Treatment-Family/Program Type require a contact log rather than a full service note.
- Documentation for Periodic and Day Services must include the *duration* of the service.

MEDICAID SERVICES SUMMARY

Medicaid Service	Recipient	Age	Supervision	Order
Case Consultation	Non-Area Program Consumers	All	All Qs	M.D. or Licensed Psychologist (i.e. Ph.D.)
Screening	Non-Area Program Consumers	All	All Qs	M.D. or Licensed Psychologist (i.e. Ph.D.)
Evaluation	Area Program Consumers	All	All Qs	M.D. or Licensed Psychologist (i.e. Ph.D.)
Outpatient Treatment Individual/Group	Area Program Consumers	All	QMHP or QSAP QDDP only for PT, OT, Speech	M.D. or Licensed Psychologist (i.e. Ph.D.)
Case Management	Area Program Consumers	All	All Qs	All Qs
High Risk Intervention Periodic Individual/Group	Area Program Consumers	Children under age 6; Children age through age 20 when provided by a professional	All Qs	M.D., Licensed Psychologist (i.e. Ph.D.) or R.N. under the supervision of M.D.
Client Behavior Intervention Individual/Group	Area Program Consumers	Consumers age 6 and over when provided by paraprofessional staff	All Qs	M.D. or Licensed Psychologist (i.e. Ph.D.)
Assertive Community Treatment Team	Area Program Consumers	Children and Adults	All Qs	M.D. or Licensed Psychologist (i.e. Ph.D.)
Day Treatment/Partial Hospitalization	Area Program Consumers	All	All Qs	M.D. or Licensed Psychologist (i.e. Ph.D.)
Psychosocial Rehabilitation	Area Program Consumers	Adults age 18 and over	QMHP	M.D.
Professional Treatment Services in Facility Based Crisis Programs	Area Program Consumers	All	All Qs	M.D. or Licensed Psychologist (i.e. Ph.D.)
Family Type Residential Treatment	Area Program Consumers	Children under age 21	QMHP or QSAP	M.D. or Licensed Psychologist (i.e. Ph.D.)
Family/Program Type Residential Treatment	Area Program Consumers	Children under age 21	QMHP or QSAP	M.D. or Licensed Psychologist (i.e. Ph.D.)
Residential Treatment-High	Area Program Consumers	Children under age 21	QMHP or QSAP	M.D. or Licensed Psychologist (i.e. Ph.D.)
Residential Treatment-Secure	Area Program Consumers	Children under age 21	QMHP or QSAP	M.D. or Licensed Psychologist (i.e. Ph.D.)

CASE CONSULTATION

Case consultation is a service provided to an outside agency or professional for a **non-area program consumer**. Typical activities billable to Medicaid are:

YES	NO
Providing information about a particular diagnosis, disability, potential services, etc.	Staff travel time.
Telephone contact with the person requesting consultation.	Time documenting in pending file, activity logs, etc.
Direct contact with the practitioner, his/her consumer, or significant others to assess situation, needs, etc.	Time in preparation -- reading reports, reviewing literature, synthesizing information, etc.

SCREENING

Screening is a service for **non-area program consumers** designed to assess the nature of a person's problems and need for services. Those activities that are typical of this service are:

YES	NO
Developing provisional diagnoses.	Staff travel time.
Clinical Evaluations -- Psychiatric, Psychological, Intellectual, Psychosocial, Neuropsychological, Forensic, Developmental/Adaptive, OT, PT, Speech, Prevocational/Vocational, Educational, etc.	Documenting in pending files, activity logs, etc.
Intake and after hours screenings.	Telephone time with the potential consumer and significant others when NOT a part of a structured interview.
Direct contact with the potential consumer and significant others to gather needed information.	Time spent writing the evaluation report.
Time spent scoring psychological/test instruments, analyzing results and interpretative sessions by a psychologist (Masters or Ph. D. level) qualified to do so, not to exceed the time spent administering the test.	Time spent scoring the psychological instrument, analyzing results or interpretative sessions by staff **other** than a psychologist (Masters or Ph. D. level qualified to do so.
Telephone time with the potential consumer or significant others when engaged in a structured interview conducted by a clinician as part of the assessment process.	
Telephone time in making referrals to other agencies.	

EVALUATION

Evaluation services are similar to Screenings with the primary difference being that Evaluations are for **area program consumers**. It would be expected that these services will be an ongoing part of consumer treatment.

YES	NO
Clinical Evaluations -- Psychiatric, Psychological, Intellectual, Psychosocial, Neuropsychological, Forensic, Developmental/Adaptive, OT, PT, Speech, Prevocational/Vocational, Educational, etc.	Requesting information.
Diagnostic Evaluations.	Contacts with other agencies to gather needed information.
Direct contact with the consumer and significant others in the application of test instruments or structured interviews.	Staff travel time.
Determination of Level of Eligibility (LOE) via CAFAS, NCFAS, GAF, DD Screening/NC SNAP, AUDIT, DAST-10, ASAM Criteria, etc.	Telephone contact with the consumer or collaterals.
Time spent scoring test instruments, analyzing results and interpretive sessions by a Psychologist (Masters or Ph. D. level) qualified to do so, not to exceed the time spent administering the test.	Time spent writing treatment/habilitation plans, documenting contacts, evaluation reports, etc.
Up to two hours of time spent in Facility-Based Crisis Programs when the consumer is not present for overnight treatment (i.e., midnight bed count.	Filling out SALs, timesheets, etc.
	Time spent scoring test instruments, analyzing results or interpretive sessions by staff **other** than a Psychologist (Masters or Ph. .D. level) qualified to do so.
	Time spent in preparation -- reading reports, reviewing literature, synthesizing information, etc.

OUTPATIENT TREATMENT

Outpatient Treatment consists of multiple activities with the goal of meeting the clinical needs of consumers. These services are performed by professional staff defined by the Area MH Program in accordance with primary case responsibility. When applied to children, the majority of activities will be the same as High Risk Intervention. The following outlines typical activities by Outpatient staff which are billable to Medicaid:

YES	NO
Therapy for mental health and substance abuse issues.	Writing treatment plans, contact log notes, service notes, etc.
Medication administration and monitoring.	Filling out SALs, timesheets, etc.
Behavioral counseling, contracts, programming, etc.	Reading, copying, mailing evaluations or other information about the consumer.
PT, OT, Speech & Language therapy.	Requesting information.
Psychoeducational activities.	Referrals for other area program services.
Education to consumers and collaterals about mental health and substance abuse issues, medication, wellness, etc., both in individual and group forums.	Telephone contact with the consumer or collaterals.
Methadone treatment and outpatient detoxification.	Attending treatment team meetings.
Consumer in-home services.	Meeting with other area program staff and the consumer/collateral when that staff bills this time to Medicaid.
Providing consultation to caregivers, service providers and others who have a legitimate role in addressing the needs identified in the service plan.	Meeting without the consumer/collateral present.
Outpatient treatment activities while a consumer resides in an acute hospital setting which are professional services NOT covered by the cost of acute care (e.g., sex offender evaluations, forensic screenings).	Staff travel time.
	Outpatient treatment activities while a consumer resides in an acute hospital setting that should be covered by staff employed as a part of the hospital per diem.

CASE MANAGEMENT

Case Management is the process of ASSESSMENT/REASSESMENT, ARRANGING, INFORMING, ASSISTING and MONITORING (APSM 45-4). Many activities are used to create this process. The following outlines typical activities of case managers which are billable to Medicaid:

YES

Filling out applications/referral forms to obtain services.

Requesting information about the consumer.

Talking with service providers about the consumer and significant others in his/her life.

Informing significant others about the consumer's status and your efforts on their behalf.

Informing the consumer about their situation and your efforts on their behalf.

Facilitating contact between providers.

Sending notices for treatment team meetings.

Facilitating meetings -- treatment team person-centered planning, mini-teams, etc.

Seeking information from anyone in an effort to obtain needed services.

Case management activities for 30 days prior to discharge when a consumer resides in a general hospital or psychiatric inpatient setting and retains Medicaid eligibility.

Writing Service Plans.

Writing reports to legal bodies which are necessary for the purpose of accessing services on the consumer's behalf.

Monitoring services in all settings including review of documentation.

NO

Writing contact log notes, service notes, etc.

Filling out SALs, timesheets, etc.

Copying, mailing or faxing information about the consumer.

Small talk with the consumer.

Training the consumer in skills.

Community integration activities.

Staff travel time.

Monitoring other area program services when the therapist, M.D., etc. bills this time to Medicaid.

Time spent monitoring **medical** care where there is no actual engagement with the consumer or service provider (e.g, watching dental care).

Court reports which are NOT for the **purpose** of accessing services.

Reading evaluations or other consumer information for the formulation of the treatment plan.

HIGH RISK INTERVENTION – PERIODIC

High Risk Intervention is a service targeted to youth under age 21 who have early symptoms or are considered **at risk** of developing symptoms of mental health, substance abuse or developmental problems. For children under age 6, both professional and paraprofessional staff may be privileged to perform HRI. When over age 6, only **professional staff** may provide this service. Each Area MH Program will develop specific criteria to distinguish between professional and paraprofessional staff. This service also includes education/training of caregivers, service providers and others who have a legitimate role in addressing the needs identified in the service plan (non-agency staff). Activities which are billable under this definition include:

YES

Group and Individual Counseling.

Staff support for consumer directed and managed activities.

Mentors.

Adaptive Skill Training in all functional domains -- vocational, educational, personal care, domestic, social, communication, leisure, problem-solving, etc.

Behavioral Interventions -- Token/Level systems, contracts, Structured Behavior Programs, etc.

Community Integration Activities.

Modeling, positive reinforcement, redirection, de-escalation, anticipatory guidance, etc.

Providing training to caregivers, service providers and others who have a legitimate role in addressing the needs identified in the service plan (non-agency staff).

Additional staff to work with the child in the school, home, community, Mainstream Day Programs, vocational settings, etc..

Recreational activities when used as a strategy to meet clinical goals (e.g., exceptional equestrians, OT activities, therapeutic camping).

Telephone contact with the consumer or caretaker.

Psychoeducational activities.

Sensory stimulation training.

OT, PT, Speech & Language therapy.

Vision therapy, Mobility training, Audiological stimulation, Communication training including use of assistive technology/alternative language, etc.

Relaxation therapy, Infant massage, Stress Management, etc.

Modeling reciprocity/engagement, Cue reading, training in developmental milestones, etc.

NO

Participating in treatment team meetings.

Writing HRI treatment plans, contact log notes, service notes, etc.

Filling out SALs, timesheets, etc.

Reading, copying, synthesizing information.

Meeting without the consumer or relevant others being present.

Staff travel time.

HRI –P activities while a consumer resides in a Medicaid funded treatment setting (e.g., ICF-MR, general or psychiatric hospital).

Residents of residential treatment facilities.

CLIENT BEHAVIOR INTERVENTION

This service is very similar to High Risk Intervention and Outpatient Treatment with the primary exception being the intensity of the service. The service is targeted to meet the MH and SA needs of consumers over age 6 when provided by a paraprofessional. Each Area MH Program will develop specific criteria to distinguish between professional and paraprofessional staff, in accordance with primary case responsibility. This service also includes education/training of caregivers, service providers and others who have a legitimate role in addressing the needs identified in the service plan (non-agency staff). Activities which are billable under this definition include;

YES

Supportive Counseling.

Staff support for consumer directed and managed activities.

Psychoeducational activities.

Adaptive Skill Training in all functional domains -- vocational, educational, personal care, domestic, social, communication, leisure, problem-solving, etc.

Behavioral Interventions -- Token/Level systems, Contracts, Structured Behavioral Programs, etc.

Mentors.

Community Integration activities.

Modeling, positive reinforcement, redirection, de-escalation, anticipatory guidance, etc.

Providing training to caregivers, service providers and others who have a legitimate role in addressing the needs identified in the service plan (non-agency staff).

Additional staff to work with the consumer in the home, community, vocational settings, etc. to ensure adequate adjustment.

Recreational activities when used as a strategy to meet clinical goals (e.g., exceptional equestrians, OT activities, therapeutic camping).

Telephone contact with the consumer or caretaker.

Time spent monitoring medical care when not directly engaged with the consumer or service provider (Waiting while the consumer receives dental care and discussing further services0.

NO

Participating in treatment team meetings.

Writing CBI treatment plans, contact log notes, service notes, etc.

Filling out SALs, timesheets, etc.

Reading, copying, synthesizing information.

Meeting without the consumer or relevant others being present.

Staff travel time.

CBI activities while a consumer resides in a Medicaid funded treatment setting (e.g., ICF-MR, general or psychiatric hospital).

Residents of residential treatment facilities.

CLIENT BEHAVIOR INTERVENTION

The activities representative of Client Behavior Intervention are essentially the same as High Risk Intervention with the exception that these are available to adults and are to be provided by a paraprofessional. **Unlike any other periodic Medicaid service, only 8 hours per day per consumer may be billed.** Below is a list of activities for CBI and the distinction between CBI and similar professional level services.

CBI	HRI/Outpatient Treatment	Case Management
Supportive Counseling.	**Individual Psychotherapy** or Supportive Counseling	No equivalent.
Behavioral Interventions -- application of Token/Level systems, contracts, structured behavior programs.	**Design** and application of Behavioral Interventions -- Token/Level systems, contracts, structured behavior programs.	Coordinating and monitoring of the Behavioral Interventions.
Implementation of Adaptive Skill Training in all functional domains -- personal care, domestic, social, leisure, problem-solving, etc.	**Design** and implementation of Adaptive Skill Training in all functional domains -- personal care, domestic, social, leisure, problem-solving, etc.	Coordination and monitoring of adaptive skill training.
Psychoeducational activities.	**Group Psychotherapy, Design** and implementation o psycheducational activities.	Coordination and monitoring of mental health interventions.
Time spent monitoring medical care even when not directly engaged with the consumer or service provider (Waiting while the consumer receives dental care and discussing further services).	No equivalent.	Time spent monitoring medical care when there is engagement with the consumer or service provider (e.g., discussing needed dental care).
Monitoring consumer behavior and response to **interventions**.	Monitoring consumer response to **treatment**.	Monitoring **services** in all settings including review of documentation.
Staff Travel Time not reimbursed.	Staff Travel Time not reimbursed.	Staff Travel Time not reimbursed.
Documentation time not reimbursed.	Documentation time not reimbursed.	Time writing treatment plans can be reimbursed. Time spent in other record documentation not covered.

ASSERTIVE COMMUNITY TREATMENT TEAM

Assertive Community Treatment Teams represent an integration of a number of Area Program services into one organizational unit providing an intensive level of service. The types of activities that this team would provide include those typical of Evaluation, Outpatient Treatment, Case Management, High Risk Intervention, Client Behavior Intervention, and Emergency/Crisis Services. **Since this service is billed to Medicaid on a monthly basis, there is no distinction between individual activities which are billable and which are not.** Specific guidelines for service implementation are outlined below:

YES	NO
Minimum staffing per team -- Qualified Professional, RN, Paraprofessional staff and approximately 6% of M.D. time.	May not bill for any other periodic services.
Recommended consumer/staff ratio of 10 to 1 with a maximum of 12 to 1.	May not bill for any month when less than 4 face-to-face contacts on different days.
Specific consumer criteria targeted to the most complex and expensive treatment needs.	
Available 24 hours per day.	
Consumers may also receive Day/Night and 24 Hour services which could be billed to Medicaid.	
Minimum of 4 face-to-face contacts on different days per month.	
May bill for services provided 30 days prior to discharge when a consumer resides in a general hospital or psychiatric inpatient setting and retains Medicaid eligibility.	

DAY TREATMENT/PARTIAL HOSPITALIZATION

Day Treatment/Partial Hospitalization (PH) is a service for adults and children which offers a variety of configurations. Day Treatment typically is a long-term treatment component whereas PH is an interim treatment for prevention of hospitalization or as a step-down from hospitalization. Per Medicaid regulations, this program must be offered minimally for 3 hours per day, although a consumer may attend for less than this time.

YES

Psychoeducational activities.

Recreational activities when used as a strategy to meet consumer goals.

Education to consumers and collaterals about mental health and substance abuse issues, medication, wellness, etc.

Basic educational skills development.

Prevocational activities.

Monitoring psychiatric symptoms.

Individual and group psychotherapy.

Behavioral interventions including token/level systems, structured behavior programs, etc.

Supportive counseling.

Community integration activities.

Support groups.

Modeling, positive reinforcement, redirection, de-escalation, anticipatory guidance, etc.

Adaptive skills training in all functional domains -- personal care, domestic, social, communication, leisure, problem-solving, etc.

Family support services.

Transporting consumers to the activities when part of the program day.

NO

Education curriculum.

Vocational activities.

Writing treatment plans, service notes, etc.

Staff travel time.

Case Management functions.

Outreach efforts when the consumer is absent from the program.

Transporting the consumer to and from the day treatment/PH program.

PSYCHOSOCIAL REHABILITATION

Psychosocial Rehabilitation typically follows the Fountain House model where consumers are "members of a clubhouse" and are responsible for management of the program with support from staff. This service is targeted for adults and must be offered for 5 hours a day per Medicaid regulations, although a consumer may attend for less than this time.

YES

Psychoeducational activities.

Prevocational Work Units -- Clerical, Maintenance, Kitchen, Newsletter, Community Service, Snack bar, Thrift Shop, etc.

Education to consumers and collaterals about mental health and substance abuse issues, medication, wellness, etc.

Basic educational skills development.

Adaptive skill training in all functional domains -- personal care, domestic, social, communication, leisure, problem-solving, health care, etc.

Community Integration activities.

Recreational activities when used as a strategy to meet clinical goals.

Transporting consumers to activities when part of the program day.

Monitoring of psychiatric symptoms.

Individual and group psychotherapy.

Supportive counseling.

Behavioral interventions including token/level systems, structured behavior programs, etc.

Family support services.

Modeling, positive reinforcement, redirection, de-escalation, anticipatory guidance, etc.

Staff support for consumer directed and managed activities.

NO

Vocational services -- Transitional Employment Placements (T.E.P.), enclaves, supported work, VR services, etc.

Case management functions.

Writing treatment plans, service notes, etc.

Staff travel time.

Transporting consumers to and from the PSR program.

Outreach efforts to consumers absent from the program.

PROFESSIONAL TREATMENT SERVICES IN FACILITY-BASED CRISIS PROGRAMS

This service is designed to support consumer needs for crisis services in a community setting as an alternative to hospitalization. Area Programs may already have these services licensed as Residential Acute Crisis Treatment and/or Non-Hospital Medical Detox. If so, this Medicaid service offers a new source of revenue to expand these services. With Division approval, other potential residential services may qualify for this funding if they are comparable in terms of program purpose and staffing. Some of the key factors to this service are:

YES	NO
Must operate 24 hours per day, 7 days per week, 12 months per year.	Social Setting Detox..
Medically supervised treatment including access to a physician 24 hours per day. Physician examination required within 24 hours of admission.	Inpatient Treatment.
Short-term service **(i.e., 15 days)** wit the goals of evaluation, intensive treatment, stabilization, monitoring consumer response and discharge planning. Typically documentation and billing will occur based upon the preliminary treatment plan or an updated service plan which includes goals for this service.	
Other periodic services may be billed when the staff person/provider is **not** cost-found to this program.	
If a consumer resides for only a portion of the day (e.g., misses midnight census), services provided may be billed up to 2 hours of Evaluation.	
Typical staff/consumer ratio of 1 to 9.	

FAMILY TYPE RESIDENTIAL TREATMENT SERVICES

Family Type Residential Treatment is a service targeted to children under age 21 which offers a low to moderate structured and supervised environment in a family setting, excluding room and board. This service provides the following activities under its core program:

YES	NO
Mentoring.	Activities provided by Medicaid funded residential programs -- Acute Hospitalization, ICF-MR, Rehabilitation Facilities, and Nursing Facilities for Medically Fragile Children, etc.
Minimal staff support/supervision for consumer directed and managed activities in all identified need areas, e.g., financial, health, self-help, vocational, educational, social, and medical planning.	Child Care Facilities which can not meet MH Licensure and Standards.
Minimal assistance with adaptive skill training in all functional domains.	Foster Care.
Behavioral Interventions for mildly disruptive behaviors -- redirection, token/level systems, contracts, and structured behavioral plans.	Run Away Shelters.
Minimal assistance with Community Integration Activities.	Respite Providers.
Modeling, positive reinforcement, redirection, and verbal de-escalation, etc.	Summer Recreation Camps
Minimal assistance with psychoeducational activities including the development ad maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management, etc.	Periodic services may not be used to augment residential services.

FAMILY/PROGRAM RESIDENTIAL TREATMENT SERVICES

The Family/Program Residential Treatment Services is a service targeted to children under age 21 which offers a moderate to high structured and supervised environment in a family or program type setting, excluding room and board. This service provides the following activities under its core program:

YES	NO
Mentoring.	Activities provided by Medicaid funded residential programs -- Acute Hospitalization, ICF-MR, Rehabilitation Facilities, and Nursing Facilities for Medically Fragile Children, etc.
Direct staff support/supervision for consumer directed and managed activities in all identified need areas, e.g., financial, health, self-help, vocational, educational, social, and medical, etc.	Child Care Facilities which can not meet MH Licensure and Standards.
Direct assistance with adaptive skills training in all functional domains.	Foster Care.
Behavioral Interventions for mildly disruptive behaviors -- redirection, token/level systems, contracts, structured behavior programming, protective devices, and de-escalation techniques, etc.	Run Away Shelters.
Direct assistance with community integration activities.	Respite Providers.
Interventions that support modeling,, positive reinforcement, redirection, guidance, etc. to consumer.	Summer Recreation Camps
Direct assistance with psychoeducational activities including the development and maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management, etc.	Periodic services may not be used to augment residential services.
Structured interventions in all identified need areas.	

RESIDENTIAL TREATMENT - HIGH SERVICES

Residential Treatment - High is a service targeted to children under 21 which offers a highly structured and supervised environment in a program setting only, excluding room and board. This service provides the following activities under its core program:

YES	NO
Staff secure and structured therapeutic environment designed to maximize the opportunity to improve the consumer's level of functioning.	Activities provided by Medicaid funded residential programs -- Acute Hospitalization, ICF-MR, Rehabilitation Facilities, and Nursing Facilities for Medically Fragile Children, etc.
Immediate staff support/supervision for consumer directed and managed activities in all identified need areas.	Child Care Facilities which can not meet MH Licensure and Standards.
Mentoring.	
Direct assistance with adaptive skills training.	Foster Care.
Behavioral Interventions -- programmatic structure with specific interventions to address the most complex behavioral and/or substance abuse treatment needs, e.g., (house rules).	Run Away Shelters.
Directed/Supervised community integration activities.	Respite Providers.
Modeling, positive reinforcement, redirection, de-escalation, guidance, etc. through staff/consumer/peer interactions.	Summer Recreation Camps
Supervised recreational activities when used as a strategy to meet clinical goals.	Periodic services may not be used to augment residential services.
Directed/supervised psychoeducational activities including the development and maintenance of daily living, anger management, social, family living, communication, and stress management skills, etc.	
Consultation from psychiatrist/ psychologist on a monthly basis.	

RESIDENTIAL TREATMENT - SECURE SERVICES

Residential Treatment - Secure is a service targeted to children under age 21 which offers a physically secure, locked environment in a program setting only, excluding room and board. This service provides the following activities under its core program:

YES	NO
Medically supervised secure treatment interventions which may include time out room, passive restraints, etc.	Activities provided by Medicaid funded residential programs -- Acute Hospitalization, ICF-MR, Rehabilitation Facilities, and Nursing Facilities for Medically Fragile Children, etc.
Structured programming/interventions to assist consumer in acquiring control over acute behaviors, verbal aggression, depression, PTSD, etc.	Child Care Facilities which can not meet MH Licensure and Standards.
Onsite consultation and supervision by psychologists and/or psychiatrists.	Foster Care.
All interventions/activities are provided under the context of this service.	Run Away Shelters.
	Respite Providers.
	Summer Recreation Camps
	Periodic services may not be used to augment residential services.